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THE

MARITIME MEDICAL NEWS

A MONTHLY JOURNAL DEVOTED TO MEDICINE & SURGERY

HALIFAX, NOVA SCOTIA.

Vol. XXI. JULY, 1909. No. 7

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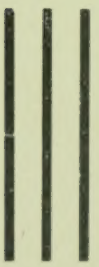

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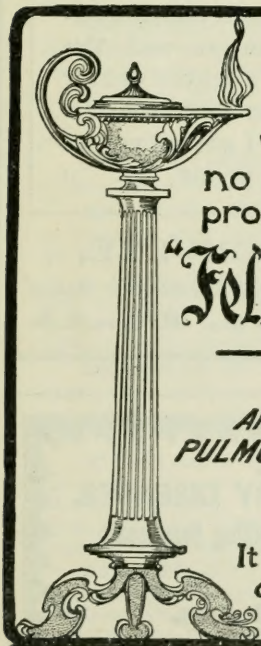

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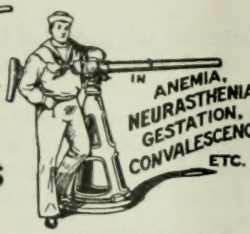

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Vol. xxi., *JULY, 1909*, No. 7.

WORLD OF MEDICINE

Habitual Constipation. Dudley Roberts, of Brooklyn, N. Y., treats constipation by finding out the causative factors and remedying them. There is no panacea for habitual constipation. The passage of the food through the bowels is accomplished by two mechanisms, reflex movements of the colon down to the sigmoid, and voluntary movements in the rectum. The stimulus to the reflex mechanism is given by the chemical irritation of the intestinal contents and the stretching of the intestine by gas and liquids. Peristalsis comes from centers in the spinal cord. Emotions may affect them. The sigmoid and rectum form a collecting reservoir; states of fullness cause a desire to empty the bowel. Here voluntary effort has its part. We must determine the site of failure to act in order to cure constipation. The study of the colon involves palpation of its parts and study of size, condition and fullness of these parts. Digital examination of the rectum after a day without cathartics will show whether the mechanism of defecation is faulty by the presence of soft feces in the rectum. If the trouble is higher up the rectum will empty. The color, form, and consistency of the stools give information, with chemical and microscopical examination of them. Disturbances of defecation may be neurotic, or they may be caused by pain in evacuation, or a tight anal muscle. Failure of the muscles of defecation may be the result of stretching of the abdominal walls. Exercises of these muscles are most valuable. Anal abnormalities, fissures, and hemorrhoids will cause constipation by pain and spasm of the muscles. The colon peristalsis may be at fault. Constipation may be the result of underfeeding, or sedentary habits, or of enteroptosis. The colon may be atonic spastic. Each one of these conditions has its appropriate remedies, which the author outlines.

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Climatic Cure of Tuberculosis. In a somewhat lengthy article, E. S. Bullock and C. T. Sands, Silver City, N. M. (*Journal A. M. A.*, June 19), review the evidence for the climatic cure of tuberculosis, illustrating their argument by tables joining the comparison of results of sanitorium treatment at high altitudes with those in institutions nearer the sea level. They find in their tabulations that, in spite of the generally inferior and more advanced class of cases treated, the government, military and naval sanatoria at Fort Bayard and Fort Stanton show better results than some of the best institutions in the East, viz., the Adirondack Cottage Sanatorium, the Massachusetts and the Rhode Island State Sanatoria. The difference is not great but it is in favor of the high altitude sanatoria in the West, and the difference is most marked in the advanced cases, which

in the two government institutions, comprise 60 per cent. of the whole. The authors have also made a comparison between their own institution, the New Mexico Cottage Sanatorium, and the Loomis Sanatorium at Liberty, N. Y., as presenting the most favorable results under respective climatic conditions. They have taken pains to eliminate the personal equation so far as possible, and offer their statistics as impartially and conscientiously compiled. At the Loomis, in the incipient class, they obtain 62 per cent. of apparent cures; in the moderately advanced class, 16 per cent.; and in the far-advanced class, 3 per cent. At the New Mexico Cottage Sanatorium, the authors report in the incipient class, 83 per cent. of apparent cures; in the moderately advanced class, 50 per cent., and in the far-advanced class 13 per cent. Combining the statistics of the three western sanatoria, there are of apparent cures, in the incipient class, 56 per cent.; in the moderately advanced, 24 per cent.; and in the far-advanced 6 per cent. Against this there are in the five lower level eastern sanatoria percentages of 47, 7, and 0.6 respectively. There is nothing but climate and altitude to which can be attributed these striking differences. The financial question here intervenes, however, and it is no use to send any patient to a high climate unless he can have sanatorium treatment and control, or can at least have as favorable conditions as he could have at home. The authors find that the blood pressure as tested in 350 of their patients averaged 130 mm. of mercury, as against 100 mm. found by Dr. Thayer of Baltimore, and suggest that this may may be one of the reasons why high altitudes are beneficial. They are not enthusiastic in regard to the tuberculin treatment, which they have seen followed by disastrous results. If used at at all, it should be used only by those trained to its use and never by general practitioners of medicine. No one can insure positively against unfavorable reaction from its employment. There may be cases in which it alone will effect a cure, but an examination of statistics of Bullock's experience and of those of the Adirondack Sanatorium has not shown better results with its use than without. The more favorable post-discharge figures in tuberculin treated patients, he thinks may be due to the fact that patients who take tuberculin best are those who are naturally most resistant to tuberculosis. He speaks highly of the hypodermic use of citrate of iron for the secondary anemia of tuberculosis, and calls attention to the striking results obtained in their sanatorium in the treatment of laryngeal tuberculosis. By direct application of cent. of apparent laryngeal cures, formalin solution thrice a day, they have obtained apparent cure in 18 per cent. of cases of combined pulmonary and laryngeal lesions, and 35 per cles. The colon peristalsis may be The recently published work of Lockard of Denver ("Tuberculosis of the Nose and Throat," St. Louis, 1909, C. V. Masby Co.), will give those desiring them, the details of the treatment.

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The Sanatorium Treatment of Tuberculosis. Maurice Fishberg of New York (*Medical Record*, June 12, 1909), believes that we can get just as good results in the treatment of cases of tuberculosis at home as we get in sanatoria. The solution of the problem lies rather in the building of better homes of the working classes than in sending them to sanatoria, which are expensive to build, equip, and

maintain. These institutions are not economically profitable. The statistics of their results are misleading, inasmuch as they get rid of all unfavorable patients and keep only incipient or favorable cases. Autopsies show that tuberculosis has existed at some time during the life of a very large proportion of persons who die, and without sanatorium treatment these cases have recovered. The secret of treatment is to raise the resisting power of the individual, which can be done by sanitary reforms, better tenements, and better feeding. The results in dispensaries are about as good as in sanatoria. With patients treated in better homes and cared for medically in dispensaries, all those able to work will be able to aid in the maintenance of themselves and their families. For all these reasons the author concludes that it is useless to multiply sanatoria for incipient cases, it being of more value to supply the incurable with a home where they can live without danger of infecting others.

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Ophthalmology and General Practice. A. A. Hubbell, New York (*Journal A. M. A.*, June 26), in his chairman's address before the Section on Ophthalmology of the American Medical Association, after first noticing some features of the program, speaks of the insufficient attention given to ophthalmology in medical schools and the too limited qualifications of the general practitioner in this line. Too many physicians are inclined to dismiss eye cases, and the result is the encroachment of the still more unqualified commercial "optometrist." There is some complaint also to be made of the professed ophthalmologist who too often begins his work as a specialist with a too superficial knowledge of the subject and without experience in general medicine. The tendency to separate ophthalmology from general practice too exclusively, is also a harmful factor as is also the lack of any legal qualifications beyond that of the general practitioner for any specialty. As to the remedy, Hubbell says that we can first strive to disabuse the public, the profession at large, and the medical school authorities that ophthalmology is so suited to exclusive study and so separate from other departments of medicine that it should be set off by itself and made only a voluntary subject for study and practice. It is not difficult to comprehend, and the diseases of the eye are the last that should be excluded from the physician's practice, as they are to be found everywhere, and with an ordinary knowledge of the subject, the general practitioner can do very much good and render to his patients the assistance they are entitled to expect. Accompanying a change in public and professional sentiment in this way there should be a corresponding change in medical teaching which will enable the general practitioner to acquire a sufficient amount of ophthalmic knowledge to meet his future needs as a family physician. The subject should not be a voluntary one in his medical course and it should be sufficiently taught to qualify the graduate to treat all ordinary and infectious diseases of the eye, to distinguish between mild and severe ones, to treat injuries of the eye which are superficial and uncomplicated, and to examine for refraction errors and correct at least the simple forms. He would add also a supplementary examination by the state board covering these points, the successful passing of which would be one of the conditions for license to

practice. This would be a check to any neglect on the part of medical schools. It is unfortunate that no qualifications for practice have heretofore been required of the ophthalmologist other than those of the general practitioner. The absence of these and the presence of a dominant spirit of commercialism have, on the other hand, caused in many cases too much haste in beginning this special practice after finishing undergraduate work, with perhaps a few weeks in post-graduate studies. Ophthalmologists are increasing in number and the unqualified ones are also increasing in number. In order that protection may be secured against unqualified ophthalmologists he suggests that the course and subjects of study should be regulated by law, and that special boards of examiners should be appointed to determine his fitness for practice and authorize a license in this specialty. But the qualifications that it should demand are extended and thorough post-graduate study of every new subject bearing on ophthalmology, personal experimental study in the laboratory, and personal clinical work in a hospital or in his preceptor's private office. He offers these propositions to the section and, if accepted, recommends the appointment of two committees, one to determine the amount of qualifications to be demanded of the general practitioner, and the other to determine and secure the necessary changes and the qualifications of the ophthalmologist specialist.

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Compensatory Albuminuria. Heinrich Stern of New York (*Medical Record*, June 26th, 1909), says that albuminuria can occur without kidney disease. Structurally sound renal membranes permit the passage of albumin from the blood under certain conditions. The kidneys endeavor to maintain a definite concentration and osmotic tension of the blood. The appearance in the urine of certain pathological substances is not due to disease, but to healthy and forcefully working organs. It is a regulatory kidney action, compensating for imperfect action of other vital organs. When the quantitatively and qualitatively normal urine contains albumin without the presence of renal inflammatory products, oil globules, shreds, casts, and many renal epithelia, we has compensatory albuminuria. Only healthy and strong kidneys can eliminate unconverted albumin not sufficiently fixed in the blood. When this burden becomes too heavy the kidneys become functionally insufficient, and later structurally affected. The immediate cause of albuminuria is a surplus of circulating albumin, or the inability of the blood to attach itself to certain albuminoid material. These albuminurias should be easily differentiated from diseased kidney conditions.

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Prophylaxis in Infants. The reduction in infant mortality, says Thomas S. Southworth, New York (*Journal A. M. A.*, July 3), in his chairman's address before the Section on Diseases of Children of the American Medical Association, has not been so great as we had supposed before the publication of the researches of Newman in England and Stowell in this country. This need not surprise us much if we consider the growth of the slums in great cities and the decreasing prevalence of maternal nursing. The improvement of antenatal conditions is a sociologic rather than a medical question, but much can be done by the profession

toward decreasing the early mortality of children. A careful study of the problem has convinced Southworth that women do not of choice neglect their children, but have often prematurely weaned their infants from bad advice. He shows how large a part ignorant midwives may play in this matter, but medical men are also partly to blame. Instead of weaning, the breast milk should be still utilized and supplemented by other methods under medical supervision. Turning our attention now to the exclusively bottle-fed babies, we find ourselves much better equipped to cope with difficult case. He does not speak highly of the percentage system as practiced, but criticizes the tendency to employ a very limited number of inelastic formulas. The supervision of the growth and development of the bottle-fed infant, as practiced, leaves much to be desired. It should not be left to the mother or nurse between the seventh and twentieth months, and periodical and regular inspection are certainly advisable. Diet is not the only factor needing medical oversight. Next to a normal proportion of muscular tissue, the hemoglobin may be called the most important index of the child's resistance. Parents seldom notice any slight pallor, and fresh air in abundance and at all times is one of the most effective agents in producing good blood. A complete rearrangement of the infant's hygiene may be even more effective than the administration of iron in bringing about improvement. Fresh air, however, alone, without attention to its unobstructed entrance to the lungs is not sufficient, and possibly no single factor recently employed has been more effective that the attention given to hypertrophied tonsils and adenoids. There is still much to be done as full inspection will show. Valid contra-indications are rarely seen to early surgical attention to these matters, even before the expiration of the first year of life if symptoms of mouth breathing are present. The neglect of children's teeth is also mentioned by Southworth as not fully appreciated, and the eye also should receive attention, as it has of late years. In fact it has been much less neglected than the ear, which has only begun to receive prophylactic attention The ear is especially implicated in many infectious diseases and the conscientious physician who wishes to do his full duty must carry with him in his pocket the means of examination of the ear. More cases of otherwise unexplainable temperature can be traced to the ear than to any other complication, and these cases can be relieved by paracentesis. This is the conservative operation, according to our modern ideals, as by relieving congestion in cases of effusion, it limits the process and aids recovery. There is less apparent glory in patient prophylaxis and conservative methods than by later successful intervention, but prophylaxis is and should be the ideal of our profession.

Occupation Neuroses. J. Madison Taylor, Philadelphia (*Journal A. M. A.*, July 17), gives his personal experience in the treatment of over forty cases of sensory and motor disabilities of the arm, due mostly to neuritis. His object is to offer to practitioners, measures which each one can readily apply and effect prompt and permanent cure. Success is largely dependent on the appreciation by the physician of the underlying condition, and the treatment in his cases was carried: (1) on along the lines of constitutional regulation, using of drugs, etc., adapted from the

interpretations of Dr. Sajous: (2) relief of psychic hypertension or misdirection by educative persuasion, relaxation of the whole organism, and teaching of economy in the expenditure of force; (3) quieting of the irritated vasomotor subcenters and improvement of their nutrition. The underlying conditions of neuritis are due chiefly to agencies affecting the normal defensive power of the blood. There is often a history of previous constitutional disease which reduces the functions of the pituitary body, according to Sajous's teaching, which Taylor follows. The phenomena are usually those of hypocatabolism, acidosis and autointoxication. Among the exciting causes the most common is cold, especially when one is exhausted, and also infectious disease. The measures to be taken against these factors are drugs causing vasodilatation, such as the bromids and chloral; drugs that cause vasoconstriction by stimulating the sympathetic centers, such as morphin, atropin, etc., and local remedies causing local reflex vasoconstriction; measures which directly deplete perineural arterioles such as venesection, cupping, and hot applications, etc.; measures which tend to eliminate the causes of the neural congestion, such as laxatives, and dietetic regulation, and lastly to combat the gouty state by stimulation of the adrenals. As regards the second point, relief of psychic hypertension, his experience is that the value of persuasion and educative measures can not be underestimated in the treatment of these cases. He goes into detail in regard to manual methods and manipulations and the importance of the physician's tactile dexterity in determining the degree of irritations and relieving them by frictions and pressure along the nerve courses. Stroking lymph channels with the affected nerve paths is, chronogically, one of the first of the indicated procedures. It should be performed centripetally and slowly, gradually increasing the pressure and taking about two minutes time, and followed by squeezing of the entire limb from the extremity to the shoulder. He is enthusiastic as to the value of the application of judicious and graduated stretchings, along with torsion, which can only be safely done by the physician, gradually increasing the force until, after two or three weeks, the patient can stand a good deal of force without marked discomfort. He thinks this is one of the most efficacious methods of relieving pain, aches, heaviness, and of restoring vigor, The re-education in co-ordination required should be carried on for months or years. After each passive treatment it is well to direct the patient to extend the arm and fingers with increasing force, and to hold the tension at the end of the act for three or four seconds, and to repeat the procedure, followed by rotation in various directions. This series of active movements should be insisted on for months, to be used three times a day. Occupation neuroses are generally the outcome of over-use of the arm in a flexed position, long maintained, and this kind of training in extension gives the normal physiologic relief.

HÆMATURIA: PAPILLOMA OF KIDNEY.

With Case Report of a Case of Papilloma.

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HAEMATURIA or blood in the urine is a condition frequently met with. The amount of blood found in urine may vary in quantity from a few corpuscles, discoverable only by the microscope to a condition in which it appears to be composed almost entirely of blood in a liquid or clotted state. The source of the bleeding is a lesion of some part of the genito-urinary tract, and the pathological conditions acting as causative factors are many. A proper understanding of this condition is the more easily obtained by a routine investigation of the urinary tract from the external urinary meatus, upwards to the kidneys, and a study of the pathological conditions of the several parts of the urinary apparatus.

It is scarcely necessary to mention that in the female, blood from some part of the genital tract may contaminate the urine, and it is first necessary that such a source of bleeding should be eliminated.

Hæmaturia may be classified according to its causation into the following:

1.—Hæmaturia due to certain constitutional diseases.

2.—Hæmaturia due to parasitic diseases.

3.—Hæmaturia due to urethral conditions.

4.—Hæmaturia due to vesical conditions.

5.—Hæmaturia due to ureteral conditions.

6.—Hæmaturia due to renal conditions.

Osler says that the diagnosis of hæmaturia is usually easy. The discovery of blood in the urine is a simple matter, as the microscope will readily reveal the presence of the red blood corpuscles. To diagnose the source of the bleeding, that is whether it is from the urethra, bladder or kidneys, may be easy in some cases while in others it is difficult, but to make an accurate diagnosis of the pathological condition causing the hematuria is a question demanding a knowledge of the symptoms and physical signs of all diseased conditions of the urinary tract.

As an aid in arriving at a diagnosis we have at the present day many modern appliances, the use of which are of great benefit. Of these may be mentioned the urethroscope, by which a visual examination of the interior of the bladder can be made and by which the ureters can be catheterized. In Kelly's cystoscopes we have very convenient instruments by which an examination of the female bladder is easily made, and by which the ureters can be catheterized. The segregator is a simple and convenient instrument by which the urine from each side of the bladder is drawn off through separate catheters. Where the prostate is much enlarged this instrument does not work well. A few months ago its value was demonstrated to me in a case I will later report. The value of the X-ray in locating calculi is so well

known and the microscope is now so generally used that further mention would be superfluous. In the *British Medical Journal* of November 7th, 1908, Dr. W. T. Brook gives an address on "the value of chromocystoscopy in the diagnosis of renal diseases," in which he conclusively points out the value of this method in determining the functionating power of the kidneys. He injects one drachm of a 4 per cent. solution of indigo-carmine (sulphindigotate of soda) into the gluteal muscles and in about twenty minutes it is excreted by the healthy kidney colouring the urine blue. An examination with the cystoscope at this time shows the presence or absence of blue jets of urine escaping from the utereal orifices, and he demonstrated by cases cited how by this method he has been able to say whether a kidney the seat of hydronephrosis, tubercular disease, etc., should be removed or drained. As practitioners I think we too often neglect to make use of some of the diagnostic aids referred to. There is probably too great a lack of confidence in our ability to use these methods, thinking that it is only in the hands of those specially trained that an instrument such as the cystoscope can be successfully used.

The relation in which the blood and urine are passed is a strong indication of the source of the hæmorrhage. This is best ascertained by having the patient urinate in three separate vessels; if the urine in the first vessel contains the most blood, the latter comes from the urethra or prostate; if the third vessel contains the greater amount of blood, the bladder is probably its source, whereas if the urine in all three vessels is intimately mixed with the blood, the kidneys are at fault.

I.—Haematuria Due To Certain Constitutional Diseases.—This class includes purpura hæmorrhagica, scurvy, hemophilia and leukæmia conditions described by some writers as the hæmorrhagic diathesis. In purpura hæmorrhage may be very profuse, being along with hæmorrhage from the other mucous membranes, the cause of grave anæmia. In these cases which are rare the hæmorrhagic spots under the skin along with the bleeding from the mucous membranes will aid in the diagnosis.

In scurvy of severe degree, hæmaturia may be present, but it is not a common symptom. Associated with the hæmaturia, are swollen and spongy gums, which bleed easily, petechia on the arms trunk and legs, hæmorrhage from the mucous membranes, ænemia and a condition of profound debility.

In a report of 334 cases of hemophilia sixteen had hæmorrhage from the urethra. Some writers speak of a recurring hematuria from one kidney in hemophilia, but Osler says that this condition does not belong to the true disease at all.

In leukæmia hæmorrhage from the urinary tract along with the other mucous membranes is not an uncommon symptom.

II.—Haematuria Due To Parasitic Infection.—The Bilharzia Hæmatobia and the Filaria Sanguinis Hominis are each the cause of hematuria. The Bilharzia lives in the venous system—chiefly the portal vein—also the veins of the bladder, kidneys, spleen and mesentery. The adult worms inhabit the vesical veins and their ova are discharged through the mucous membrane, causing hæmorrhage which may be severe enough to cause anæmia. In eastern countries where this parasite is frequently found it is the cause of an endemic

hæmaturia. Diagnosis depends on finding the ova in the urine.

The Filaria Sanguinis Hominis may cause hæmaturia alone, but very frequently the blood is associated with chyle and the urine has an opaque milky appearance, with a pinkish sediment containing blood clot. This condition of the urine is intermittent, the patient often passing perfectly clear urine for long periods of time. Some times the bladder contains numerous clots which are difficult to pass. Diagnosis depends upon discovery of the embryo in the blood or urine.

III.—Haematuria of Urethral Origin.—The causes of hæmorrhage from the urethra are traumatism instrumentation, new growths as polypi and papillomata, impacted calculus. The amount of bleeding from any of the above is slight except from the traumatism when it may be quite severe. The source of the blood is easily made out, as the first part of the urine passed contains blood, while the latter part is comparatively clear or free of it. An examination by the urethroscope will locate the source of the bleeding except in the posterior part of the urethra.

IV.—Vesical Origin.— Hæmaturia of vesical origin is usually an indication of more serious trouble that that of urethral origin, and as a healthy bladder is so necessary for the comfort of the individual, it is very important to ascertain the cause of a symptom like hematuria. The causes are rupture of the bladder, tumours, simple and malignant, calculi, tuberculosis, simple ulceration, varicose condition of the veins, parasitic infection.

In rupture of the bladder hæmaturia will always be present, but the amount of blood or blood stained urine is not an indication of the seriousness of the injury. A very small quantity of such urine may be obtained by the catheter due to its extravasation through the tear. The history of an injury in the bladder region will help clear up the diagnosis.

In tumours of the bladder hæmaturia is a very prominent symptom in some cases. Papilloma and carcinoma are the most common growths, and the hæmorrhage from either is very erratic. It may be slight or so profuse as to cause clotting in the bladder with retention of urine, due to obstruction by the clot. The bleeding from these tumours is intermittent, extends over a long period of time and is not much influenced by physical exercise.

Diagnosis of these growths can easily be made out by the cystoscope after the bladder is emptied of blood-stained urine. An examination of the urine for bits of tissue cast off from these tumours, or of foreign cells, along with the relation with which the blood and urine are passed, will in many cases indicate the nature and source of the trouble.

There is nothing special of the hæmaturia of tuberculosis of the bladder. It is intermittent, and usually microscopic in quantity. Tubercle bacilli found in the urine or in shreds of cast off tissue, pyuria, painful micturition are accompanying symptoms which clear up the diagnosis.

Fenwick states that simple ulceration of the bladder is not an infrequent occurrence and may be cause of hæmaturia. It is situated near the trigone or neck of the bladder.

In vesical calculus hæmaturia is not a marked symptom. Blood in microscopic quantities is present and any severe exercise as jumping, jolting, horseback riding, etc., may increase it, so as to make its presence apparent by the colour of the urine. The cause of the hæmaturia can in many

cases be made clear by the sound or the X-ray.

V.—Haematuria of Urethral Origin:—On account of the size of the ureters it is not to be expected that they are the seat of conditions causing much blood in the urine. It is seen as the result of traumatism, instrumentation, impacted calculus, papillomata, tuberculosis and even gonorrhœa. The diagnosis of ureteral affection is difficult as it involves a careful cystoscopic examination, sounding and catheterization, observation of the ureteral orifices and the naure of their discharge. Where the ureters have been blocked by calculi, Kelly has had much success by the use of a wax-tipped catheter which contains the scratches left where it has come in contact with the calculus.

VI.—Haematuria of Renal Origin.—It has already been mentioned that the characteristic of renal hæmaturia is that the blood and urine are intimately mixed. Clots may also be present and are of a slender worm-like nature due to their expulsion through the ureters. The kidneys are the seat of many pathological conditions and hence most often the source of blood found in the urine. The acute inflammations, traumatism, tumours, calculi, tuberculosis, toxic agents, congestion due to twisted pedicle, are responsible for more or less hæmaturia.

In many of the specific infectious diseases nephritis is a complication, and as a result of the acute congestion blood appears in the urine varying in quantity from a few corpuscles to an amount sufficient to colour the urine a bright red.

In traumatism of the kidneys hæmaturia depends upon the seat of the injury; if the calyces or pelvis are lacerated it is always present unless the ureter is torn away or blocked by a blood clot. The gravity of the traumatism cannot be judged by the amount of hæmaturia as an extensive rupture of the kidney substance and capsule may allow an amount of hæmorrhage dangerous to life to take place into the paranephritic area, while the urine may contain little or no blood. On the other hand an extensive laceration of the calcyces may cause the bladder to fill up with pure blood.

In tumours of the kidney hæmaturia is a prominent symptom and the time of its appearance depends somewhat upon the location of the growth. Those that begin in parts of the kidney away from the mucous membrane of the calcyces or pelvis, will cause considerable enlargement before hæmaturia sets in, whereas in those growing from the calcyces or pelvis hæmaturia is an initial symptom. In an investigation of 409 cases of new growths of the kidneys (168 of which were in adults) hæmaturia was reported as the first symptom in 68.8 per cent. Israel says that it is present in 92 per cent. of all tumours and was the first symptom in 70 per cent. of his cases. In some benign growths it is the only symptom pointing to the urinary tract. The characteristic features of hæmaturia due to renal tumours are that it is spontaneous, usually profuse, may persist for some days, suddenly cease and reappear in a few hours, and may or may not be accompanied by renal colic. It may be unaffected by rest or exercise, but the former usually lessens it and the latter aggravates it. Along with hæmaturia the presence of foreign cells, absence of pyuria and deficient excretion of urea are important urinary findings. In renal calculi, the amount of hematuria varies; usually it is small, but in rare cases it may colour

the urine a bright scarlet. A daily examination of the urine shows it to be an almost persistent symptom. Rest lessens it and exercise increases the amount.

In tubercular disease there may be the same variation in quantity, but the amount of pus in the urine is much greater than in most calculi or tumours.

In moveable kidney hematuria is a symptom following a Dietl's crisis, being due to the congestion following torsion of the pedicle.

Case Report.

On May 15th, 1908, Miss McD., of Sherbrooke, N. S., consulted me at my office concerning some "kidney trouble," as she expressed it. When asked what she complained of she said that her urine was very red. On examination she was very anæmic in appearance and complained of weakness, shortness of breath and dizziness. Temp. in mouth, 99.4; pulse 102, sitting; weight 102 lbs. A sample of urine was at the time obtained and the colour was about that of port wine. A microscopic examination showed blood to be present in large quantity. A filtered specimen showed albumen present, and a blood count only gave 2,576,000 red blood corpuscles.

An inquiry into the past history of this condition of the urine showed that it dated back to June, 1907. At that time she had been to Halifax having her nose treated, when her physician told her she was anæmic and prescribed some iron mixture. Going home on the boat she had a rough passage and the next day was the first time her attention was drawn to the condition of her urine. From June until September the urine was red in colour most of the time and on being asked what part of the urine was the deepest colour she thought the latter part was. During this period there was slight soreness in the back increased by exercise. About September 25th she became very ill with hæmaturia which she said made her very weak. For a period of about four weeks there was severe pain which was worse at night. This pain was chiefly on the left side, radiated down the left leg to knee, and into left labium. On being questioned closely as to which side the pain was she said it was in both sides, but not so severe in the right. At this time numerous clots were passed which caused great pain. For a period of about nine days, patient said she had a very high temperature, and vomitted more or less for two months. Pain at periods continued until about a week before Xmas. From this time on until she consulted me there was continuous hæmaturia, with the exception of a week in March. During this period from December 1907 to May 1908 there has been very little pain. Examination of kidney region negative.

Family History:—Inquiry into her family history elicited the fact that four paternal aunts and one uncle had died of pulmonary tuberculosis. No history of tuberculosis on the mother's side.

Up to a year ago patient had average health with the exception of atrophic rhinitis. Did not have any urinary symptoms up to a year ago. After eliciting the above history patient was given a provisional diagnosis of renal calculus or growth in pelvis of kidney, with the possibility of renal tuberculosis, and advised to go into hospital for further observation.

May 25th.—She entered the hospital and on the 26th an examination of

her bladder was made. Kelly's cystoscopes were used in the dorsal position with unsatisfactory result. The segregator brought clear urine from the right catheter and blood-stained urine from the left catheter. At this time it was noticed that much less urine came from the left. An examination of the total urine at this date gave: Colour, port wine; reaction, acid; specific gravity, 1024; albumen, heavy ring; sugar, none; sediment showed red blood cells, leucocytes; no casts; urea 1 per cent.

May 28th.—Segregator was used with the same result as on the previous occasion.

On account of a daily rise of temperature of about 1° and a slight hacking cough the possibility of tuberculosis of the kidney was considered and tuberculin for diagnostic purposes was given. For twelve hours previous to the use the temperature was taken hourly, and on June 4th at 10 p. m., 3-10 m. g. Koch's old tuberculin was injected. No reaction followed.

On June 6th, 1 m.g. of tuberculin was injected with negative result, except slight soreness at site of injection. So on June 8th 5 m. g. were injected at 10 p. m. Following this was a decided reaction with the following symptoms, headache, malaise, temperature varying from 100.6° at 11 a.m. to 102° at 8.30 p.m. June 9th, pulse 116 at 11 a.m. to 100 at 8.30 p.m. This reaction either meant that there was tubercular condition causing the hæmaturia, or a latent focus in the lungs which careful examination proved to be probable. On June 12th the bladder was cystoscoped in the knee-chest position. The interior was plainly visible and nothing abnormal seen.

Dr. Victor McKay examined the urine and in the first specimen found a large number of acid fast bacilli. These were smegma bacilli, as a second specimen removed by a catheter contained none. In the second specimen there were a large number of cells which took a uniform eosin stain and looked like connective tissue cells. No casts in either specimen.

July 9th.—Segregator used. Urine from left kidney and trace of albumen. Urine from left kidney blood stained and contained albumen. Total urine gave specific gravity of 1018. Considerable albumen, urea 1.8 per cent.

An X-ray of kidney region showed nothing in the shape of calculus, but an apparent enlargement in the left kidney region.

After consultation with Dr. Chisholm, a diagnosis of either left-sided renal new growth, or calculus was given, and patient kept in bed and given tonics to prepare for operation. During her stay in the hospital complete rest in bed greatly lessened the bleeding, but a sharp walk caused it to reappear.

July 9th.—Re-entered hospital for operation. Total quantity of urine passed in 24 hours was about 31 or 32 oz. An examination of the segregated urine gave 2.53 per cent. of urea from right side showing that kidney to be eliminating a large quantity. Urea could not be estimated accurately from left side as the quantity was insufficient.

On July 11th the patient was operated on and the left kidney exposed. It was found to be very large and hard to deliver on to the back. When delivered it revealed cystic portions where the cortex was. Palpation of the kidney revealed a good sized

growth and removal of kidney decided upon.

The time required for the operation was short and the patient left the table in good condition with a pulse of 89. The convalescence of this patient was anything but a smooth one and on two occasions within the next month she was very ill. Ether was used as the anæsthetic, setting up bronchial trouble in about 24 hours, and on the second day she was so sick I was afraid she would die. On account of the extremely rapid and weak pulse I was suspicious of hæmorrhage from the pedicle, so had the dressing removed and found the wound to be alright.

The question that now arose was "would the remaining kidney do the necessary work," so I had the total quantity of urine passed in 24 hours measured. The evening of the day she was operated on, she was catheterized and 9 oz. of dark red urine removed. This was no doubt due to the manipulation of the kidney and hæmorrhage from the growth. In the next 24 hours she passed 23 oz. of urine and the estimation of urea was 1.8 per cent. For three days after the operation she was extremely ill, during which time nothing would make her sleep. Following this her condition became much better and she did nicely with the exception of a troublesome cough and an occasional rise of temperature, until July 28th, when she became quite ill. During this time she had an erratic temperature varying from normal to 104°. This trouble I believe was the lighting up of an old pulmonary focus, so she was put out of doors in bed during days when fine, and made to take all the good food possible. Due to this she soon got better and left for home on August 13th, in fairly good health. Patient some months after is in excellent health.

Examination of Kidney.—On opening the kidney a tumour the size of a large egg is seen occupying the pelvis. The latter is much dilated and a portion of the tumour has extended into the infundibulum of the ureter. The attachment of the tumour at its base is sessile. On examination this growth was shown to be a papilloma which in the kidney is a rare condition.

HINTS OF THE PROGRESS OF PREVENTIVE MEDICINE.

By G. E. DeWITT, M. D.,
Wolfville, N. S.

Read before the Annapolis-Kings Medical Society, June 24th, 1909.

WE hear more of preventive medicine to-day than we did fifty years ago. We hear less frequently that diseases are the Will of Providence and must have them. It is not so often heard in the household that the children must have children's diseases: as measels, scarlet fever, and whooping cough. Why? Because we have been taught that they are preventible. Since the discovery of the germs of disease, the parent has been taught that the old sink deposit or cesspool, with its fermentation and decomposition, is a nest to propagate and develop disease germs and that decayed or decaying vegetables beneath living rooms, hold these agents in waiting, ready to attack the susceptible system of the child. We have learned that the old well, contaminated with surface drainage, has been the source from which has sprung an epidemic of typhoid in this fair valley, leaving its death trail and wail of mourning in many homes. We have learned that a pure water supply coming from the hills for the consumption of the household is a preventive of typhoid fever. We have learned that the quarantine of contagious and infectious diseases and thorough cleansing of the premises, will effectually prevent epidemics.

Drugs Have Their Place.

While the profession is trying to instill into the minds of the people the necessity of prevention, by using reasonable sanitary means for the checking of disease, the thought seems to be growing in the minds of the people, that the efficacy of drugs is not as potent as the professor would make it appear. Faith healers and psychological teachers, or those who have promulgated the doctrines of suggestion, have had something to do with the intrenchment of the thought. But the old practitioners, if there be such, who proclaim that drugs are not conducive to the cure of disease, have forgotten the therapeutic and physiological action and value of medicine, of which he was taught in his youth and seen demonstrated a thousand thousand times in battling with disease. So long as the animal man is subject to pain, so long as his system is invaded with the germs of infectious and contagious diseases, so long as the sins of the fathers shall be visited upon the children, to the third and fourth generation, will drugs be necessary to control, alleviate and cure. While I do not deny the aid that suggestion can give to the psychological action of medicine in the treatment of disease, I have not got so far in my second childhood as to ignore the fact, which I learned in clinical study and since verified by observation and experience, that drugs judiciously used and administered in the treatment of disease, are as necessary to combat, alleviate and cure it, as water is essential to quench thirst, and food to the nourishment of the system.

The little child tossing upon its pillow in pain, rebels at the sight of the teaspoon, that holds the soothing

draft, but the sedative and alleviating effect it produces is not from any psychological act or suggestion, but from the physiological effect of the drug. The adult who reposes confidence in his physicians, as he carefully outlines the mode of administration of his medicine, does, I have no doubt, bring to the aid of the drug, a certain psychological condition, which assists the physical. But the man who impresses upon his patient the idea that drugs, though he gives them, are of very little value, hinders to some extent their physiological action. Lest I may leave the impression that I am contradicting the opinion heretofore given of the value of drugs, in diseases, let me say that neither one or the other extreme can be the most successful. Man is given the faculty to think and reason and it is when the the psychical and physical are blended, that there will be the most happy results.

Scientific research has taught, and is teaching, that hobbies are dangerous horses to ride; that healing the sick is not all of this, or of that. Each patient is a law unto himself and he must be treated, not exactly as another was treated with a disease of the same name, but as indications are individually expressed. The faith cure is a dangerous hobby, because we are taught that "without works our faith is dead." The psychological or suggestion cure alone is a ship without anchor or rudder. I know that it cannot be denied that the use of some drugs may have been overdone and we may also affirm that certain practices in medicine in treating the sick, have at times been overdone, and because of their over use have become almost obsolete, when to have practised them in moderation, or in such cases where the indications demanded, they would have been of value. The over use of blood-letting practised in this country sixty years ago was, doubtless, over done, and because of its over use, the practice is seldom heard of now. The treatment of the sick depends upon the happy combination or selection of such agencies as are best indicated and which will most effectually bring about the desired result. But the faith cure, the psychological cure, the rest cure, while in conjunction with other reasonable means may be conducive in combating disease, yet, their isolated and extreme use is often harmful, unscientific and dangerous.

Typhoid Fever.

I have referred to a pure water supply, as a preventive of typhoid fever. A pure water supply, except from the artesian system, can only come from the hills protected by the forest. In introducing the subject of forestry into my address I am not bringing in a subject foreign to it. The forest has much to do with preventive medicine. Without the forest our climate would be changed and unbearable—brooks, rivers and lakes would be dried up and the country uninhabitable. It will take but a glance at the past to bring to the minds of many the mortality caused by typhoid fever even in this valley a half century ago. Although this disease is not yet totally eliminated, it is because of an impure water supply. Thirty years ago there was not a water supply from the hills or pipe system in any of the towns from Yarmouth to Halifax. Halifax only excepted.

I vividly recall an incident of 52 years ago, in the autumn of '58, of seeing a doctor on horseback, riding with his horse upon the run to a patient, to find him stricken with a severe attack of typhoid fever. The

doctor commenced to dose with opiates, purgatives and astringents. The patient lived for fourteen days in spite of the treatment and then passed beyond his reach. The doctor came day after day, but he did not look into the water supply for use in that house, to see whether it was contaminated with surface drainage or not—whether a sink drain was in close proximinity to it or not. This incident was one of hundreds which occurred in the Annapolis Valley in this and subsequent years, taking from the home the bread-winner, son, mother, or daughter.

With the knowledge that typhoid fever is a waterbourne disease and that a contaminated well which supplied water to the household was the chief source of infection, together with the added knowledge of the discovery of the typhoid bacillus, were the incentives to put into operation the means of prevention, by investigating the water supply, by ridding wells of surface drainage, by doing away with the old exposed sink drain, by disinfecting and destroying the excreta of the patient. But the most striking example of the prevention of typhoid fever in this valley, and the same example exists the world over, wherever the same means are used or measures adopted, was in bringing from the hills a pure water supply for domestic purposes. I have referred to the water supply system in the towns and villages of the Annapolis Valley. Since then typhoid fever has been reduced to a minimum in these places. In the town of Wolfville, where I reside, there have been only three or four cases of typhoid within the last 16 years, and what is true of Wolfville is true of all places where the water supply is uncontaminated.

The point I wish to make is that it is essential to the welfare of this valley to preserve the water-shed. To preserve, perpetuate and protect the the north and south of the valley, for it is from them comes the unadulterated water supply. To preserve the water-shed of this valley is not only a question of economy and wealth, but of health. The water supply can only be maintained by the preservation of the forest on the hills and hillsides. Can one imagine, or picture, a greater calamity to this valley, than the complete denudation of the land, which supplies water to the towns lying between the North and South Mountains. Do I hear some farmers say, "But we need the land for pasture." That is true, and pasture he can have, for he can so regulate the cutting of his forest as to preserve the wood in strips, especially upon the hillsides, and have pasture between the strips of woodland. By this method his pasture would stand longer in the time of drought, erosion of the soil would be prevented and seepage of the rain and snow would take place, filling the springs and storing it for the household. If the water supply for domestic purposes which has been brought into the towns and villages for the last 25 years has been a blessing of preventing typhoid fever and other infectious diseases, would it not be a boon for every hamlet in the valley to have a pipe system water supply where available. In may localities a group of a half dozen, or dozen or more houses could be supplied from one main pipe. Do I hear that the expense is too great? Is it as great as the lack of it, which brings disease, suffering and doctors' bills, and in many cases death? The water thus brought into houses by gravitation, brings with it

the modern bath room and other conveniences, which are necessary to the comfort, sanitoriness and health of the household.

The Annapolis Valley.

I wonder if we have any realization or conception of our heritage? Girded and sheltered by the North Mountains, in which are meandering brooks, tidal rivers, rich meadows and dyke lands, orchards of the apple, the quality of the fruit unexcelled by any other country upon the face of the globe. The scenery from many a viewpoint from seed time to harvest, pronounced by the tourist to be equal to and often excelling any other in their experience. Beautiful as it is, it can be made more charming, more sanitary and conducive to wealth, comfort and health, by a judicious preservation and perpetuation of the forest.

Tuberculosis.

My address, though incomplete and imperfect, would be more incomplete did I not refer to the subject in some of its aspects, the consideration and study of which is doing much to enhance the progress of preventive medicine. Since so much has been said upon the subject of tuberculosis in the lay and medical press, and upon the platform, what more can be said? And since so much has been done in treating tuberculosis in sanatoria and the home, what more can be done? The theme has not become threadbare, the nap upon the texture has scarcely commenced to be worn. Although a great effort has been made all over the world to successfully treat and stamp out the disease, yet the fringe of the means to be used in eradicating the plague has only been touched. While we read of the great effort made in other countries in combating the disease in sanatoria, in free hospitals, in isolated retreats with greater or less success, yet, the question comes home to us with as great significance as ever, what shall be done with our consumptives who live in what we term the breeding places?

What shall be done with the consumptives in this valley? This is a problem that will have to be grappled with sooner or later, a problem for the municipalities, a problem for the taxpayer. When the people realize that consumption is an infectious disease and claims more victims in the Annapolis Valley than all of the other infectious and contagious diseases combined, there will be a more direct effort made to control it.

The provisions already made by government in establishing a Provincial Sanatorium, as laudable as the undertaking may be, is inadequate. The institution has its place and will always be a necessary adjunct in combating the disease, by caring for as many cases as its capacity will accommodate, but it cannot reach the vast majority of extreme cases, which are of the greatest danger and menace to the community.

We have yet to get into closer touch with the idea which is fast gaining ground, that the cure of the sick, especially those who are afflicted with infectious diseases, is not so much an act of charity as a public duty. It is a public duty to assess property to keep up the highways, to support the public schools, to build court-houses and jails, and to support the poor whose circumstances are such as to make them dependent upon a community. In an equal sense, is it not as imperative for the public to prevent the spread of infection, which pauperizes and decimates the people? Thus far, the movement against tuberculosis has been confined mostly to

the cities or large centres of civilization, where the breeding places of tuberculosis are more numerous and greater than in the rural districts.

TUBERCULOSIS IN CHILDHOOD.

What shall be done with tuberculosis children in this valley? What shall be done with the child who has tuberculosis? The public schools don't want him, because of the danger of infection: and for another reason, he should not be confined in house air six hours of the day. Private schools don't want him, for the same reasons. Shall he be kept at home and dosed with numberless medicines said to be good for the disease, or dosed with the so-called advertised consumption cures which are a delusion and a snare? An elaborate treatment with medicine for the consumptive is to be deprecated anyway,—the simpler the remedies the better. The few simple remedies necessary to maintain the vigor of the child, with plenty of fresh air and isolation from other children in the home, are the essentials of treatment.

The medical profession have data to encourage the belief that the majority of adults who are diagnosed with tuberculosis, have contracted the disease in childhood. Recent medical literature has shown that in hospitals and infirmaries in England, where children have died from accident and various diseases, it has been found that 30 per cent. of them had tuberculous lesions, and it follows, that if these children are representative of the child population, 30 per cent. of the children living have tuberculosis: yet death certificates being from children is less than one per cent., which shows how hard it is to diagnose the disease in children and how necessary it is in order that we may eradicate the disease, to furnish the child with the best sanitary and hygienic surroundings during childhood. A child living in rooms, or a house where a consumptive has lived and perchance died, without using the necessary precautions to destroy the germs of the disease, is up against a danger of infection and reinfection, which only a few of the many can escape. Take the tuberculous children out of the school-house. Teach them in the open air, away from the non-tuberculous Teach them in the open air all the year round, when the weather will permit. When the weather will not permit, give them drill exercises in a well ventilated room—the exercises of deep breathing, chest development. Tuberculous children should not be subject to the grind in the schools, that the well are subject to.

There is a school conducted in Franklin Park, of Boston, where children sit out of doors, 30 of them, all through the school hours. These children are all consumptive. All through the last winter, since January 16th, these children have been steadily gaining. They prove on blackboards that two plus two equals four, with chalk tightly grasped in mittened fingers, while they waddle around like mammoth ducks, in bags lined with wool. This unique school is conducted by a young lady who is interested in the children. They commence their lessons in the open air at 8.30 in the morning, from then until noon they study at their desks. Through the morning they have breathing exercises and many other things to break up the monotony; at the noon hour they have lunch and then gou out upon the roof wrapped in blankets in camp chairs for an hour's sleep, then work until 3.30. At 5.30, they are given dinner and sent home. Of 43 who commenced at that school in the autumn, 23 have been sent home cured. One unique feature

of the school is that every pupil is required to keep a record of his or her temperature and weight, which incites a rivalry and competition among them to carefully follow the instructions which are given them for their advantage. A gentleman of the profession said to me the other day, "The only fault I find with you in your advocacy of fresh air, is you claim that any fresh air is good for the consumptive." My reply was, "That while drier and less changeable climates are more quickly conducive to the cure of the consumptive, that any fresh air is better than house air, and if fresh air in the month of March in Boston is good for the consumptive, the fresh air of Nova Scotia is equally as good."

The medical profession recognizes today that there are two important agencies of tuberculosis. One standing for its propagation and the other for its elimination, are ignorance and education. It is the influence of the former that nurses the breeding places and scatters the seeds of the latter, which scatters the seeds of the latter, and it is the influence of the latter which is arresting and controlling it.

The tuberculosis exhibits which have been held in New York and Philadelphia within the last six months have done much to stimulate the campaign against the plague. Especially has this been the case in the effort made to educate the children. These efforts have been the means of establishing camps and parks in the cities, where the tuberculous poor were brought in many instances with their families from the alleyways and slums, and where they had pure air, sunshine and nourishing food. They have been the means of instructing thousands of children in the simple rules of prevention, of making a more vigorous inspection of the children in the schools, of impressing upon the people the necessity of cleaning out the places of infection and of keeping them clean, of making and adopting a more rigorous method of the inspection of milk and meat and other articles of diet, of the necessity of making it imperative upont he landlord to thoroughly disinfect a house where a consumptive has lived before another tenant is allowed to occupy it. The great feature of the exhibit in Philadelphia was the education of the children. The children of the schools to the number of 1,000 were daily taken through the buildings by competent instructors and the meaning of the different objects explained to them. Prizes were offered for essays of their impressions of the exhibition. This kindergarten teaching of the children in many of the essential principles relative the treatment and cure of the tuberculous must be of material aid in educating the budding generation in the preventive measures of this and of all infectious diseases.

There is no effort being made or means used to-day that will be of more value in the future in stamping out the white plague than the impressions made upon the children as to the nature and cure of the infection of tuberculosis. Dr. A. H. Woods of Philadelphia, speaking at the exhibition, discussed and deprecated the demand of patients suffering with tuberculosis for elaborate treatment. He championed the cause of simple remedies in consumption and scored in striking terms the quack doctor who advertises and sells a sure cure for consumption. He also emphasized the fact that popular education in the schools is the best means of educating future generations, and at the same

time the present generation, in the means of preventing tuberculosis.

Special emphasis was made by some of the authorities at the exhibition in reference to giving children drugs when exercise was needed and would do far more good. It is far better, where it is applicable, to prescribe physical exercises for children, than to use a drug, because exercise is a natural means of altering, strengthening and developing the different tissues in the body. Drugs as I have previously said, have their place and are employed to change the pathological to physiological conditions. There is no safer means of strengtheniing the constitution of weak and delicate children than by exercise, because by this means every organ and tissue of the body receives new blood and receiving new blood is greatly benefitted when auxiliary conditions of diet, sleep, ventilation, clothing, bathing and sunlight, are added.

There is so much to be said regarding the subject of tuberculosis that is necessary to say in the campaign against the disease, that one in a short address is at a loss to know what is best to say to a public audience which will be of the most service, and as it is wiser not to talk too long to an audience on a summer's night, and that there may be ample time for discussion by those who know as much or more than myself, I will say but a few words in closing concerning the exaggerated fear of tuberculosis which exists among the people and fraught with much harm and a serious impediment to the progress of the propaganda. The efforts made in the campaign against tuberculosis are not only to stop the spread of infection from the advanced cases, but to reach the early cases and bring them back to health. An authority has said: "When we have reached the early cases and have shown them the road back to health, there will be few advanced cases."

The exaggerated and insane fear that exists among many people regarding the disease is a hindrance to the discovery and treatment of the early cases. The early case is often kept away from the physician, because if it were known that he or she was tuberculous his or her occupation would be taken away and hence the disease is often hidden until it is so far advanced that unfortunately too little can be done. What we have got to do in our crusade against the disease is to get at the early cases among the poorer classes, where because of a lack of appreciation of cleanliness, sunlight and fresh air, the disease is propagated.

The exaggerated fear of which I speak is not merely confined to the poorer and ignorant class, but often do we find it among the educated and those in the better walks of life. A doctor was called up upon the 'phone by a lady to come to her house to see a patient. Before the doctor got under way, the 'phone rang again, and the lady in the most anxious tone, said: "Doctor, I have just learned that you treat consumptives. Please don't come. I would not have you treat my baby for anything." Such instances as these would only excite our amusement, were it not that the notion is a false one and seriously hampers the movement against tuberculosis. The profession is using every effort to bring the people to understand that tuberculosis is only a dangerous transmissible disease when very simple precautions are neglected. Tubercle bacilli are not sitting astride the person of the tuberculous ready to jump down the throat of every indi-

vidual who comes near him. The atmosphere of the consumptive's room is not a place to fear. It is not an atmosphere of living death. The people have got to believe, as the profession has told and is telling them, that when the consumptive has taken proper care of his sputum and has regarded and exercised the ordinary decencies of right living, that he is a menace to no man. When these precautions are taken one can live with a consumptive in well ventilated and lighted rooms without risk. An authority has said that the tubercle bacillus hates fresh air, cleanliness and sunlight as the devil hates holy water. The crux of the whole question is right living. Diagnose and treat the early cases. Let the children live in well lighted and ventilated rooms and out of doors all that is possible. Give them plenty of nourishing food. Teach them to eat fat when they are well and not wait until they are sick to dose them with cod liver oil. Do away with the damp cellar, the undrained soil around the house. Keep potatoes, cabbages and turnips and all vegetables in a cellar away from the living rooms as we would avoid a death trap. Then we will have limited the spread of tuberculosis. Then we will have a stronger and more vigorous generation and opened up a new era of better manhood, physically and morally.

A SPECIALTY FOR THE GENERAL PRACTITIONER.

By E. H. BENNETT, M. D.,
Lubec, Maine.

Read before the annual meeting of the Maritime Medical Association, Charlottetown, July —, 1909.

IN 1882, Professor James Wood of New York, in a lecture at Bellevue, said: "Gentlemen, if this craze for specialization continues, it will not be long before there will be a doctor for the *small* intestines and another for the *large*."

This prophecy has been more than fulfilled, and the question arises, "Is specialization in medicine being overdone?" It is doubtful whether any well informed physician could be found to-day who would claim that any one mind was capable of mastering all there is in the science and art of medicine. This would be much more difficult to-day than a quarter of a century ago, and will continue to become more and more difficult as the years go by, as each year adds much to the available knowledge the student must master.

Then if it is absolutely necessary to specialize, where is this to stop? At the point where it ceases to strengthen, to improve, to broaden, to make more impregnable the entire profession in its great work against the ravages of disease. Some have feared that in this race for specialties, the general practitioner would be driven from the field. This, perhaps, imaginary evil will be greatly influenced by the efficiency attained by the general practitioner himself. Still, it behooves us to get into the swim, become specialists ourselves, be recognized as such, secure a seat in the front row, and make better fees.

Some may ask, "Where do I expect to find an empty seat in the specialist's ampitheater?" There is room for one in the center, the most prominent position of all, quite as enviable as that of the surgeon on the right, or the gynecologist on the left; equally as responsible, its occupant entitled to add as many ciphers after the significant figures in the fee bill. Although the time honored *family* physician has in a measure gone out of business, the general practitioner is still the man on the "firing line." He it is who renders *first aid*, who sees the patient in the acute, the incipient, often the remediable stage, when as general on the field, if he can anticipate the enemies' move before it is actually made, is much more likely to win the battle. "To be forewarned is to be forearmed."

One of the most important duties of the general practitioner is that of *classification*. When this has been properly done, a long stride has been made toward success. This responsibility, this duty is especially his. It is second in importance to no other. If classification means *much* in educational work, in almost all pursuits of life, it means *most* in the practice of medicine.

Professor William Osler, one of your most brilliant countrymen, says: "In the fight which we have to wage incessantly against ignorance and quackery among the masses, and follies of all sorts among the classes, diagnosis, not drugging, is our chief weapon of offence. Lack of systematic personal training in the methods of the recognition of disease leads to the misapplication of remedies, to long courses of treatment when treatment is useless, and so directly to that lack of confidence in our methods which is apt to place us in the eyes of the public on a level with empirics and quacks."

What is necessary then, in order that the general practitioner may be able to properly classify his cases? Simply that he be an *expert diagnostician;* a specialist in diagnosis. This then is the specialty I would offer the general practitioner.

After returning from a difficult case of herniotomy requiring resection of a portion of the small intestine, which had been unrecognized until the patient was nearly moribund, Professor Maurice H. Richardson, said: "I wish Harvard graduates would learn to diagnose strangulated hernia."

Dr. Murphy of Chicago declares "Procrastination and its direct sequel —death—still dominate in both intestinal and hernial intestinal obstruction, notwithstanding the clearly defined, differential diagnostic signs and symptoms."

According to Dr. Brinton's statistics "43% of fatal cases of intestinal obstruction are due to intussusception"; still, but few of these cases are diagnosed sufficiently early to offer any hope of cure by surgical interference, the only remedy.

In examination of cases belonging to this class, we have both subjective and objective symptoms to guide us and can add to this information, that gained by touch and ocular inspection; still, an early diagnosis is the exception.

In the discussion of a paper on tuberculosis, Dr. Nichols, chief physician at the Maine State Sanatorium, Hebron, Maine, stated, that in his opinion not 25 per cent. of tubercular cases were diagnosed during the incipient stage. So that three out of every four cases are not only ignorant of their true condition, but have been allowed to sacrifice the golden opportunity for curative treatment. Other authors place the per cent. even lower.

H. L. Barnes gives the following summary *of mistakes made in diagnosis*, so far as could be learned from examination and history of 200 cases admitted to the Rhode Island State Sanatorium for Tuberculosis:

1. The presumable duration of the disease before admission averaged 15.4 months.

2. 50.9% have delayed consulting a physician, such delay averaging 7.9 months.

3. 2.4% have been diagnosed "throat trouble."

4. 3% have been diagnosed malaria.

5. 12.1% have been incorrectly diagnosed without an examination of the lungs.

6. 18.1% have had their lungs examined and pronounced sound.

7. 18.7% have been incorrectly diagnosed without an examination of the sputum (sputum being present).

8. 14.5% have been diagnosed grippe.

9. 14.5% have been diagnosed bronchitis.

10. 12.7% have not been correctly diagnosed after hemoptysis.

11. 2.4% have had the correct diagnosis purposely withheld from them by the physicians.

12. 5.4% have had unclassified mistakes in the diagnosis.

13. 46% have been incorrectly diagnosed, the resulting delay in correct diagnosis averaging 11.3 months.

Dr. Billings writes: "That lack of skill in the physical examination of the chest is responsible for failure to recognize incipient disease of the lungs in many cases is asserted, and doubtless with truth, by those who have charge of sanatoria for pulmonary diseases."

Salisbury says: "The fact that with few exceptions only incipient cases are curable, should be an incentive to physicians to make the earliest diagnosis possible. It is a fact not alto-

gether creditable to the medical profession that in many cases the diagnosis is not made and the disease not even suspected until it has reached a somewhat advanced stage.

The reasons for this failure of diagnosis are various, but the chief of them are:

1. The physician does not take the trouble to examine his patient. The complaint indicates a slight affection and medicine is prescribed without examination.

2. The physician does not suspect the disease because his attention is attracted by symptoms pointing to discase of other organs. The lack of appetite is thought to be due to disease of the stomach; the pains are supposed to be neuralgic; the cough is attributed to catarrh; the fever is regarded as malarial.

3. The physician does not take pains to secure a thorough clinical history.

4. The diagnosis is decided in the negative at the first examination when subsequent investigation would have detected more definite indications of the disease.

5. The physician is insufficiently trained in physical diagnosis to recognize the earliest signs. In this connection the importance of training in physical diagnosis should be especially emphasized and the practitioner should remember that he can maintain and increase his skill in this method by percussion and auscultation of the normal chest.

Take for example tuberculosis of the kidney, which, contrary to previous teaching, is usually primary and not secondary; the first symptoms are almost always referred to the bladder. If this patient consults the general practitioner (as he is sure to do) who is not accustomed to the use of the cystoscope, catheterization of the ureters, etc., a diagnosis of cystitis is almost sure to be made, and the case treated accordingly. At this stage, the disease is likely unilateral, and a cure nearly certain by nephrectomy A year later, when the patient is *driven* to the genito-urinary specialist because of intense suffering, the disease is apt to be bilateral, and the prospect of a cure very much lessened. The year of wasted time was invaluable to the patient, but it is gone, and the patient will soon follow.

In the spring of 1906, a young man came to my office presenting all the signs of reasonably well advanced pulmonary tuberculosis. He had been treated by a reputable physician the last six months for "bronchitis." Still, the clothing had never been removed from the chest for examination purposes, and no thought given to examination of sputum. The doctor did not believe in laboratory diagnosis. This is little short of criminal carelessness. There are other things besides prescription writing for the clinician to think of.

To quote Osler again, from a lecture delivered January 6th, 1903, before the New Haven Medical Society, in which he says: "I have gone over my history cards of private patients brought or sent to me by last-year physicians, in which the disease was not diagnosed though recognizable *de visu*. Gout, pseudohypertrophic muscular paralysis, hysterical lordosis, spondylitis deformans, preataxic tabes, Graves' disease, Parinson's disease, anorexia nervosa, Raynaud's disease, pernicious anæmia, spastic diplegia, and cyanosis of chronic emphysema were on the list."

A leading physician of Boston told me last winter, they had been considering the advisability of opening a hospital for "Diagnosis" pure and

simple; there must then be a need for such an institution.

To convince ourselves that diagnosis is not always an easy problem, one has but to recall the history of appendicitis. What a variety of views were held regarding this disease between the time of Mestiviers' first reported case in 1759, and Fitz's master stroke in 1886, a period of 127 years. During this time some of the leading men of France, England, Germany, United States, Canada and Italy had apparently almost grasped the great principle underlying this condition, the full conception of which was left for Boston's great clinician — Reginald Fitz. This history illustrates another equally important fact, viz.: that *proper treatment* rapidly follows *correct diagnosis.* Notwithstanding some, so-called, perityphlitic abscesses had been opened before this, no systematical surgical treatment had been formulated.

In 1889, only *three* years after Fitz's paper was published, Dr. Charles McBurney of New York, wrote such a classical paper on "improved technic" (the first step in which was suggested by Professor Treves of London the previous year, 1888), that Howard Kelley of Baltimore, fourteen years later, said: "The article deserves to be ranked as one of the classics in the surgical history of America. So admirable and so clear are his views as to the proper surgical treatment of appendicitis, that the experience of fourteen years has not brought any radical or important change in his methods."

In a conversation on appendicitis, Professor W. T. Morris, one of New York's best operators and diagnosticians, said: "I have found during the last few years quite a large number of patients sent to me for operation, entirely relieved of all abdominal symptoms by having glasses properly fitted."

Those of you who attended the meeting of this Society in St. John two years ago, will recall the very interesting paper read by Professor Phinney of Baltimore, in which he enumerated a long list of diseases mistaken for appendicitis where he had been called to operate, including two cases of measles, one of which was operated; and these cases, as the Professor stated, all happening in the hands of reputable men.

On June 13th, a lady called at my office, complaining of metrorrhagia for six months. She was 38 years old, had three children, youngest three years old, not pregnant since; previous health good; family history negative. She attributed all her symptoms to change of life—that pitfall of womankind. Examination showed enlargement of uterus, especially the cervix, which bled on the slightest touch, sensitive, and from the right side extending into broad ligament could be felt a decided exudate. There seemed no doubt but what the patient was suffering from malignant disease, well advanced.

The next day she was taken to Portland and placed in Dr. King's private hospital. Operation the following day showed that the pelvic glands on the right side were extensively involved, so much so that an unfavorable prognosis was made. This patient will probably die within a year, and the operation pronounced a failure by her friends, while the true blame rests with the patient and her family—due to false impressions regarding the menopause—a subject which should receive much more careful thought by the profession.

"That a campaign of education can be made to produce results is proven by the experience of Winter of Ko-

nigsburg, whose results are not as well known as their importance deserves. In 1902, he undertook to improve his results in cancer of the uterus, by publishing a series of pamphlets on the early signs and symptoms of uterine cancer, distributing these not only to the physicians of East Prussia, but also in popular style to the laity at large. As a result in one year his operable cases increased from 62% to 74%. After instructions were issued, 90% of the patients applied for treatment within two weeks after first seeing their family physician. The number of cases seen within six months was reduced from 12 to 5%; cases seen within nine months, from 18 to 5%, and in those cases whose symptoms have lasted a year, the decrease was from 12% to none at all. With these statistics as a proof of what can be accomplished by one man in a year's time, certainly we should be optimistic as to the result of a general campaign of the profession along these lines."

Dr. Moulton writes: "Our present hope lies entirely in the hands of the general practitioner. He must start a campaign of education among the women of his clientele. All women approaching the cancer age, have, as a rule, some physician to whom they look for advice, and who occupies to them the position of "father confessor" in all affairs medical. If the family doctor will impress upon these women the necessity, as they approach the menopause, of reporting to him any changes in the character of their vaginal discharge; if he will even go to the point of impressing upon his patients the value of a *routine* vaginal examination at least once in every six months in women between the ages of thirty-five and fifty-five, whether they have any symptoms or not, the statistics of operable cancer of the cervix will take their place along those of the breast. Cancer of the cervix does not differ in its biology from cancer on the visible surfaces of the body, and could it be seen in the same stage of its development, it would be just as amenable to surgical cure."

A word in reference to the obstetrical field. Here we mention only a few of the complications of pregnancy and delivery. Placentia previa: Hirst, quoted by Dr. F. S. Newall of Boston, stated that in the hands of the general practitioner, a mortality of approximately 40% was present in complete placenta previa, but believed in the hands of experts the ordinary mortality should be in the neighbourhood of one per cent., or in other words, an accidental mortality.

Dorman, in his series of 84 cases, the initial hæmorrhage was first noticed about the sixth month in all cases except eight. In three of the latter it appeared in the second month. In half of his cases the hæmorrhage was moderate at the outset, gradually increasing and independent of labor pains. In 10% of the cases the bleeding began slowly after the beginning of labor, and in 40% there was a sudden profuse flooding, in one-third of which slight preceding attacks of bleeding had given warning signs.

De Lee comes to the following conclusions regarding treatment: "Before viability of the child unless the hæmorrhage is frequent or profuse, expectancy may be practised, but the patient must remain in bed and in a hospital. After viability of the child, it is best to terminate pregnancy. One may, at the urgent request of the family, wait a few weeks, but the patient must remain in bed and in a well-equipped hospital."

What does the experience of these men (which might easily be indefinitely extended) teach us? Simply that the diagnosis of Placenta previa

should be made early, and the patients placed under the care of experts. The same principles hold good in cases of contracted plevis, where Cæsarean section would show nearly a hundred per cent. of recoveries of both mother and child. The same operation is being advocated in Placenta previa.

Dr. Stanley Warren of Portland, Maine, who has a large consultation practice, in discussing a paper on Eclampsia, said: "I find that many physicians do not make routine urinary analysis in these cases." This being the case, how are you to foretell the storm which is liable to break over your patient at any moment?

Along the same line we may consider diseases of the digestive tract, benign and malignant. A patient calls at the office of the general practitioner, having diagnosed her own case and asks for something for "Dyspepsia" or "Indigestion." After a few indefinite questions some routine prescription is handed out. Do we always stop to consider that co-called Dyspepsia is but a symptom and not a disease, and a symptom of what? Of a variety of pathological conditions, as hyperchlorhydria, hypersthenic gastritis, asthenic gastritis, myosthenic gastritis, ulcer, stenosis, cancer, achylia gastrica, to say nothing of a long list of diseased conditions of liver, pancreas, duodenum, and surrounding tissues. This prescription would surely need to be of the shot-gun type, and even then will miss oftener that it will hit the mark. If this same patient should consult a specialist the first thing to be done is to establish a supposedly correct diagnosis. A careful history is written out, each symptom given its proper place and weight. Modern methods are taken advantage of, a complete analysis of gastric contents, chemical and microscopical is made, a careful urinary analysis and blood count are not neglected.

It is self-evident that for the best interests of the patient this should all be done when the patient first presents herself for advice, and not afterward, when, in many instances her only chance for recovery has been lost. If then, the best interests of the patient are to be secured, a correct diagnosis must be made by the general practitioner who should be the specialist in this work.

A CORRECTION.

62 Coburg Street,
St. John, N. B., July 5, 1909.

Editors MARITIME MEDICAL NEWS:

SIRS,—In the paper, "Myopia," which you were good enough to publish, I notice a few errors, some by myself, a few by the compositor. For instance, on page 217, 5th line, *converged*, instead of conveyed. The error of my own was in saying the rays can be well represented by the section of a cone *perpendicularly* to its base instead of *parallel* to its base. This is also on page 219 9th line. Page 219, 31st line an unnecessary "c" was added to to the word *contractile*. On page 219, 20th line, I am made to say *satisfactory* instead of *unsatisfactory*, which I meant.

Yours,

G. R. J. CRAWFORD.

ANEURISM.

By H. *D. HAWBOLDT, M. D.*

Stewiacke, N. S.

I AM REPORTING this case of Aneurism principally because of the severe symptoms, and the near approach to death of the patient, and also to report that he is now on a fair way to recovery. There is nothing in the patient's past history that is of any particular interest. He worked in the lumber-woods three year ago and says he rather prided himself in taking heavy lifts. In the winter of 1907 he began lumbering again, but on account of general weakness and shortness of breath, had to give it up. For the last two years he has been under my observation. He has during all this time complained of great shortness of breath, and a bloating of the veins of neck and arm on the least exertion. His kidneys and heart have always remained normal. I treated him during the winter of 1909, with poor satisfaction, because of doubt of the diagnosis.

In the past spring I sent him to the Victoria General Hospital for treatment, and if possible to clear up the diagnosis. While he was there I called on him twice and consulted with physicans attending him. Although they were in doubt they decided to call this case one of Aneurism, and put him on light diet and Pot. Iodide.

He left the hospital about May 1st, unimproved. Up until the middle of May he was on Pot. Iodide, but during this time the symptoms grew much worse. The dropsy increased and his general health became much impaired.

At this time I put him on Tr. Digitalis M 10, with Tr. Nux Vomica every four hours. He did not stand the Tr. Nux Vomica well, as it produced great twitching of the muscular system. I gave him quite heavy doses of Tr. Digitalis for three or four days, but the dropsy grew worse and his condition became very alarming. Fluid appeared in the peritoneal sac, and the right pleural sac became filled, from which forty ounces of a straw colored fluid was taken. A clear fluid almost trickled from his arms and legs, and the skin became copper-colored, and he developed a peculiar skin disease. A rash would appear intensely itchy, then this would turn to silver looking spots about the size of a pea: even the top of his head was covered. From the scratching his body in parts became crusted over with scabs.

His left lung became congested; in fact his whole system became water-logged. Something had to be done as the patient was sinking very rapidly.

In addition to the heavy doses of Tr. Digitalis and keeping the bowels well open with Magnesium Sulphate, I decided to try him on Calcium Chloride grs. five every four hours. Two days later I visited him and found he had improved. His heart was beating about 65 per minute. The mind had become clear, and as the patient himself put it, he was "*getting well.*" I continued this treatment, keeping the patient quiet, and in six days he had lost sixty-three pounds in weight and looked like a skeleton of his former self.

When the dropsy left him there remained a bulging of the second and third ribs, beginning at the sternum

and extending outwards for about three inches. This, to my mind, cleared up the diagnosis. If it was a growth the dropsy would not leave, or if it was due to adhesions or any other obstruction other than Aneurism, the circulation would not become normal on the addition of Calcium Chloride to the treatment.

Although very dilapidated in appearance his organs all remained practically the same or normal.

He always had a very irritating cough (due to pressure on the vagus nerve), which still remains, although not nearly so bad since the lungs are not so congested.

I believe Calcium Chloride did the work in this case by acting directly on the blood and making it more coagulable. I have had some experience lately in treating nose-bleed with this drug and have always got good results.

Now, the important points in this case, are:—

1st. The severe symptoms that developed due to obstruction of the circulation, and the obscure diagnosis.

2nd. The quick relief due to Calcium Chloride aided by Tr. Digitalis.

3rd. The going away of the dropsy and the clearing up of the diagnosis by the remaining bulging of the second and third rib, and the remaining cough, due I believe to the irritation of the vagus nerve.

The patient is now gaining flesh and strength and doing well in general and should make a good recovery.

TWIN LABOUR, CO-INCIDENT PLEURISY FOLLOWED BY PNEUMONIA—A LARGE PLEURAL EFFUSION—RECOVERY.

By DR W. H. IRVINE,

Fredericton, N. B.

Read before the N. B. Medical Society, St. Stephen's N. B., 1908.

GENTLEMEN.—The unusual nature of this case induces me to regard it as worthy of your attention.

You will pardon omission of clinical details, as they would add nothing of interest and only consume time.

On March 10th, 1908, I attended Mrs. F., age 34, third confinement. Palpation revealed plural pregnancy, and labour well established, the os being dilated about the size of a half dollar, and a history of pronounced chills several days before, followed by lancinating pains in chest, short dry cough, superficial respirations, rapid pulse, and a temperature of 102 F., distinctly pleuritic friction sounds over lower aspect of right lung.

In fact, the pleurisy pains seemed more distressing than those due to labour, naturally affecting the respiratory movements thus aggravating the pains generally.

In order to conserve her strength, delivery was effected as promptly as possible, using chloroform and forceps, a male child was first born, weight seven pounds—vertex presentation—a female shortly followed by podalic version—weight five pounds—separate placentæ.

The following day the patient presented every evidence of pneumonia, of lower lobe of right lung.

Upon its recognition, a 10 grain dose of calomel was administered—my usual custom in pneumonia—which was followed by a profuse diarrhœic movement, yellow, flocculent and very offensive, which persisted until the crisis—8 to 15 movements in 24 hours—despite efforts to control the same, the character and odor of the discharge being such as to lead one to suspect a possible typhoid element, no other symptoms of the latter developing, and its prompt disappearance at the crisis, removed all uncertainty in that regard.

On the the fifth day, things looked most discouraging, temperature at 5 p. m., 104.5; delirium, coma vigil, tongue thick and heavily coated, sordes on teeth, efforts to remove thick, tenacious sputum which accumulated in pharnyx and trachea, which along with the above mentioned diarrhœa, and constant cough, presented a picture both unusual and distressing.

Coincident with the crisis, which appeared on the 8th day following labour, the diarrhœa disappeared, and a hydrothorax rapidly supervened, filling the right chest quite up to the anterior axillary line, patient in the dorsal decubitus, which after lasting about eight days began to be absorbed, disappearing quite as promptly as it came on, and in a month's time from her confinement she was able to be up for a short time.

I might add that she was much below par physically, very thin, but

fortunately throughout her entire illness, was able to take nourishment and retain it well.

The only drugs employed, except for the diarrhœa, were the preliminary dose of calomel, quinine grains, 10 every 6 hours, brandy ad lib. and with egg-nog, etc., and petrogen iodide applied freely to chest.

The coolest and airiest room was used, blankets next the skin and heat to the lower extremities.

You will note that the leading features of this case were:—

1. The extreme rarity of the physiological and pathological complex.
2. The persistent diarrhœa which, doubtless, through its depletive action, largely diminished the sources of toxæmia, which otherwise would have been more pronounced.
3. The promptness and thoroughness of recovery.

The children are vigorous and thriving.

NOTES OF A RECENT VISIT TO THE KENTVILLE SANATORIUM.

By D. A. CAMPBELL, M. D.,
Halifax, N. S.

Read before the Medical Society of Nova Scotia, at Sydney, July 7 and 8, 1909.

THE object of this short communication is to evoke discussion rather than to deal exhaustively with the work which has been done at the Provincial Sanatorium during the past five years.

It is very generally felt that some changes are now necessary to improve the work of the institution and place it on a higher level.

During the year 1899 the profession in Nova Scotia manifested unusual interest in the cure and prevention of tuberculosis. This found expression in memorials sent to the government by representative organizations. These efforts were greatly strengthened by an able and exhaustive report prepared by the late Dr. Edward Farrell, Halifax, who officially represented the Government of Canada at the International Congress on Tuberculosis, held in Berlin in May, 1899.

The following year the Government of Nova Scotia, influenced by these various considerations, secured authority from the legislature to build, equip and maintain a sanatorium for the treatment of patients suffering from pulmonary tuberculosis in the early stages of that disease. It was found that it would be impracticable for the government to provide an institution capable of accommodating all forms of tubercular disease amenable to treatment, occurring in the province. It was, therefore, deemed best to construct and support a small but thoroughly equipped sanatorium which would serve as a model for like institutions that, it was expected, the various towns and municipalities, and perhaps private corporations, might make provision for in the near future.

In carrying out this work, advice was freely and widely sought. The selection of a suitable locality, the choice of a site, the design of the building, the internal equipment, and the management of the institution were decided upon only after mature consideration and consultation with competent authorities both at home and abroad.

A site containing eighteen acres was selected, on high ground overlooking the town of Kentville.

The plans for the building were drawn by I. W. McGregor, architect, of Montreal, under the direction of Dr. A. J. Richer, an excellent authority on the subject. Dr. Geo. L. Sinclair, in one of his reports, speaks of the building as follows: "The build-"ing is designed to accommodate "eighteen patients, and each will have "a separate room, besides quarters for "the resident staff and domestics. "There are spacious verandahs, com-"fortable sitting rooms, and the house "will have hot and cold water, electric "lighting and hot-water heating—in "fact all the comforts of a home. Struc-"turally, everything is strictly up-to-"date. There is plenty of space on "the grounds to erect cottages, should "increased capacity at this particular "site be thought desirable, or the "structure could be duplicated or "triplicated in other parts of the pro-"vince."

The building was completed in 1904 and cost about $20,000. It was opened

on the 1st of June of that year for the reception of patients.

The institution was placed under the care of a resident Matron Superintendent, Miss Elliot, a trained nurse, who had spent some time at the Massachusetts Sanatorium at Rutland, and also at a private sanatorium at Sharon. She was provided with ample assistance in the way of nurses and domestics.

A visiting physician, Dr. Woodworth, of Kentville, was appointed.

Two medical examiners residing in Halifax, Dr. Chisholm and myself, were appointed, and the number was subsequently increased to nine. Our chief duty was to determine whether applicants for admission were suffering from pulmonary tuberculosis in the incipent stage.

The procedure for the admission of patients is as follows: To apply to the Superintendent, Miss Elliot, at Kentville. If there is room for a patient a set of blanks will be sent the applicant, who will then present himself to one of the medical examiners. If as a result of his examination the case is considered a suitable one for sanitorium care, security for board will be required by the government, and that given, an order will be issued, upon presentation of which the superintendent of the sanitorium will receive the patient as an inmate. It must be remembered that only cases in the incipient and curable stage will be admitted, *and that this condition must be decided by the medical examiner, whose decision is final.*

For each examination the examiner is paid three dollars by the government without referring to results, that is, rejected applications are paid for, as well as those favourably reported upon.

The maintenance rate, which includes every charge, was at first fixed at $8.00 per week. This was subsequently reduced to $5.00 per week, a rate which cannot be regarded as excessive.

From June 1, 1904, to June 1, 1909, there were 298 patients admitted to the institution. Of this number, 245 are available for classification, and here I may say that the best authorities think it necessary that patients should be classified on admission, on discharge, and according to ultimate results.

A classification based on ultimate results is not possible at present, owing to lack of information. Such a classification would afford the most reliable knowledge of the work done, as the division into living and dead after the lapse of two or three years after discharge admits of no personal equation or variation of definition.

The conditions on which admission and discharge supply sufficient information to justify some positive conclusion respecting what has been accomplished by the institution, and also why it has failed to realize the results which were expected by its advocates:—

I.—Conditions on Admission.

Year.	Incipient.	Advanced, with favorable symptoms.	Far advanced.
1904-05	24	26	14
1905-06	21	22	20
1906-07	15	19	25
1907-08	13	26	20
	73	93	79

II.—Conditions on Discharge.

Year.	Apparently cured.	Improved.	Not improved.
1904-05	20	30	14
1905-06	13	33	17
1906-07	6	34	19
1907-08	13	26	20
	52	123	70

The results are more clearly brought out by another classification, that is, by combining the two tables already presented. Total number of patients, 245.

	Apparently cured.	Improved.	Not improved.
Incipient....	7.3(20 p.c.)	15.60 p.c.)	30.54 (p.c.) 0
Advanced....	9.3 (10 p.c.)	9.10 p.c.)	75.80 p.c.) 9 (10 p.c.)
Far advanced	7.9 (3 p.c.)	0 (0 p.c.)	20.8 p.c.) 59
	245	52	125 68

It is very evident from these figures that the Kentville Sanatorium is capable of doing excellent work, if the admissions are confined to truly incipient cases. The 60 per cent. of apparent cures in incipient cases is a very good showing and compares favourably with the results obtained in other sanatoria.

It is also clear that the medical examiners have, in some cases, failed to do their duty by the admission of some patients far advanced in the disease. Why have the examiners permitted so many advanced cases to secure admission to the Sanatorium? I cannot speak for the examiners as a body; for my own part I can only say that I have not had sufficient courage in some instances to tell applicants plainly that it was useless for them to go to Kentville.

It is also apparent from the small number of applicants in the incipient stage of the disease, that the profession generally are very indifferent as to the advantages of the Sanatorium. The reasons for this apathy are many, but lack of confidence in the persons entrusted with the management is a conspicuous one. Their view is well expressed in the following extract of an editorial in the MARITIME MEDICAL NEWS, of May, 1901:—

"It is said that a resident medical "superintendent is not likely to be ap- "pointed. We trust the report is in- "correct. The profession recognizes "that successful results can only be "obtained by close attention to the "many and minute details of treat- "ment which require constant modifi- "cation to suit individual cases. Each "case will call for close and continu- "ous study and the exercise of tact, "and no one except a specially trained "medical man can carry out the work "and enjoy the confidence of the "medical profession and patients."

Personally, I hold a high opinion of the capability of the present officials. Miss Elliott is a clever, capable woman. Dr. Woodworth is a shrewd, well informed, general practitioner. All of the patients without exception, whom I have sent to the Sanatorium, speak highly of both, and of the care and attention which they have received.

With much of the criticism to which they have been subjected, I have very little sympathy, because they have had to shoulder the sins of others. At the same time I am not oblivious to the fact that neither singly nor conjointly can they fill the place of a properly qualified resident physician, and the government should speedily recognize that the confidence of the profession cannot be extended to the institution until their views are carried out. The foregoing covers the facts up to the date of the latest official report in October last, but subsequently to that date and down to the time of my visit, the new patients, while slightly fewer in number, contain a larger proportion in the early stages of the disease.

SOCIETY MEETINGS.

Medical Society of Nova Scotia, July 7th and 8th, 1909.

THE fifty-sixth annual meeting of the Medical Society of Nova Scotia was convened at the Court House, at 9.30 a. m. The President, Dr. A. S. Kendall, M. L. A., in the chair.

The report of the Committee on Arrangements was read by Dr. Bruce, the local secretary.

The minutes of previous annual meeting were read and adopted.

Reports of Committees.

Dr. Hattie, for the Committee on Education, asked that the report be deferred until next day. On motion, the request was granted.

Report of Committee to Deal With Dr. Stewart's Address.

Dr. D. A. Campbell, for the Committee on the Presidential Address of 1908, reported as follows:—

Your committee appointed to consider the presidential address presented by Dr. John Stewart at the last meeting of the Medical Society of Nova Scotia, beg to report as follows:

1. The medical profession of Nova Scotia recognize the value of the Provincial Medical Board, and appreciate the excellent work which this Board has accomplished in securing desirable legislation and in protecting the interests of the profession in various ways. Your committee would ask that this confidence be emphasized by hearty co-operation with the Board on the part of each member of the profession.

2. It is to be regretted that the Board is at times hampered by lack of funds, and it is suggested that this Society advocate the adoption of an annual fee of say $2.00, and that the desire of the profession throughout the province in the matter should be learned by ballot.

3. It is felt by your committee that if such a fee should be adopted, the Provincial Medical Board would be in a position to make the Maritime Medical News its official organ, and furnish each enregistered physician with a copy free of charge.

4. Your committee are also of the opinion that the costs of suits for prosecution of illegal practitioners should not be made a tax upon the funds of the Provincial Medical Board, but should be met either by a special tax or by the creation of a new organization somewhat upon the lines of a Medical Defence Union.

5. It is the opinion of your committee that any suggestion as to reorganization of the Board should come from the Board itself rather than from an outside source.

All of which is respectfully submitted.

W. H. Hattie,
W. B. Moore,
D. A. Campbell.

Referring to clause 3, Dr. Campbell stated that the committee felt rather diffident about the suggestion contained in this clause, as two of its members were on the editorial staff of the News. He thought that there was now special need of instituting new means of revenue to the Provincial Medical Board since the examination fees were lessening in their amount yearly.

It was moved by Dr. Mader, seconded by Dr. J. W. McLean, that the

report be discussed clause by clause. Carried.

Clause 1 passed without discussion.

Clause 2 passed after the addition thereto of the following words: "And that the Provincial Medical Board be asked to take the ballot before the next meeting of the legislature."

Clause 3 passed, it being explained by Dr. Campbell that the scheme proposed was similar to that in vogue with the P. E. I. Council.

Clause 4. After some discussion it was moved by Dr. Mader, seconded by Dr. Eagar, that this clause be considered twelve months hence. Carried.

Clause 5 passed.

It was moved by Dr. Eagar, seconded by Dr. Ross, that the report as amended be adopted. Carried.

Report of Committee to Deal With Dr. Arthur Macdonald's Communication.

The committee to deal with the communication of Dr. Arthur Macdonald of Washington, D. C., read at the last annual meeting, reported through Dr. W. B. Moore as follows:

Your committee appointed to consider the communication from Dr. Arthur Macdonald, Honorary President Third International Congress of Criminal Anthropology, presented to the last meeting of this Society, beg to report as follows:

It is the wish of Dr. Macdonald that this Society pass a resolution favouring the establishment of "a laboratory under our government for the scientific and sociologic study of the criminal, pauper and defective classes, with a view to lessening or preventing social evils by investigation of their causes."

Your committee find that in Canada the criminal classes are dealt with by the federal government, the defective classes by the provincial governments, and the pauper classes by the municipal authorities. Under these circumstances considerable difficulty would doubtless be experienced in conducting a laboratory in which all the classes would be studied, unless the federal government were to assume control and secure the co-operation of the other governing bodies.

Your committee are impressed with the great importance of the subject. The methods in vogue for the treatment and suppression of crime are conspicuously unsuccessful, and it must be conceded that if better results are to be hoped for we must revise our means for dealing with it. Recent work in criminology would indicate that crime, degeneracy, pauperism and disease are more or less closely co-related, and there is much reason for believing that they should be studied in such association. Thorough understanding of abnormal conditions requires equally thorough understanding of the normal, and the study of the normal as well as the abnormal demands very wide research. We quite accord with Dr. Macdonald's statement that "As the seeds of evil are usually sown in childhood and youth, it is here that all investigation should commence, for there is little hope of making the world better if we do not seek the causes of social evils at their beginnings," and also with his contention that "the time has come when it is important to study a child with as much exactness as we investigate the chemical elements of a stone or measure the mountains on the moon."

There can be no reasonable doubt but that well directed investigation of the conditions which make for normality or abnormality would be followed by results which would be of incalculable social benefit to human-

ity, and the medical profession should therefore be unanimous in supporting any measure which would lead to the institution of such an investigation.

Because of the already intimated association between crime, degeneracy, and disease, your committee feel that this study should properly be undertaken under the direction of one who has had a thorough medical training. It is also felt that such work might well be made a part of the duties of the Public Health Bureau which Dr. J. B. Black and others have so earnestly and eloquently advocated in the Dominion House of Commons. In order then, to give assistance to both Dr. Black and Dr. Macdonald, your committee would recommend that the following resolution be adopted and forwarded to the Prime Minister of Canada:

Resolved, That we, regularly qualified practitioners of medicine, in attendance at the 56th Annual Meeting of the Medical Society of Nova Scotia, and thereby representing the medical profession of the Province of Nova Scotia, do heartily endorse the project advocated by Dr. J. B. Black, M. P., and others, in the Canadian House of Commons, for the establishment of a Public Health Bureau, for the Dominion, and urge upon the Federal Government the great desirability of speedily providing for the establishment of such a Bureau, which should be fully manned, generously equipped, and allowed the widest possible latitude in the study and control of conditions which favour the incidence and spread of disease, degeneracy and crime.

All of which is respectfully submitted.

W. B. Moore,
G. E. DeWitt.
Per W. B. M.
W. H. Hattie.

The report was adopted as read.

The following were named as a Nominating Committee by the president: Drs. Moore, D. A. Campbell, T. N. Miller, E. Kennedy, W. H. Eagar, and the Secretary.

The Secretary-Treasurer then read the financial statement of the Society for the year 1908-09, showing a cash balance of $89.42, and that of the Cogswell Library Fund, showing a balance of $709. The report was, on motion, adopted.

In response to questions asked by members, Dr. D. A. Campbell stated that the privileges of Cogswell Library were available to every member of the profession in the province, but that very few had taken advantage of them.

Accounts against the Society were read by the Secretary-Treasurer, and passed.

A letter from Dr. Elliott, Secretary of the Canadian Medical Association, respecting affiliation with that body, was read.

The following committee to deal with this matter was appointed by the president: Drs. M. A. B. Smith, J. G. Macdougall, and E. Kennedy.

There being no further business the president called on Dr. A. R. Cunningham of Halifax, who read a paper on "Headache," considering the subject chiefly from the standpoint of ophthalmology.

Dr. Moore, in discussion, referred to the increasing prevalence of eye defects in school children, due in some measure, he thought, to the modern curriculum of the schools and the bad lighting and ventilation often found in the buildings.

Dr. Hattie read a paper on "Huntington's Chorea." Dr. D. A. Campbell complimented Dr. Hattie on his paper. He himself had the good for-

tune to see a few cases with Dr. Dickson of Londonderry. He noticed that the German writers make no reference to Huntington's name in describing the disease, one of them calling it "Chronic Hysteria." In Nova Scotia it seemed to be confined to descendants of the French Huguenots.

Dr. W. McK. McLeod of Sydney, read a paper, "Observations in Mastoid Trouble, with case reports."

Dr. Chisholm asked for the diagnostic points between superficial and deep Mastoiditis. He cited a case of his own in which the predominant symptom was hæmorrhage.

Dr. E. Kennedy mentioned two similar cases.

Dr. A. F. Buckley, of Halifax, read a paper, "Mineral Waters, and their uses in Medicine."

Dr. M. A. B. Smith thought it well that attention had been drawn to this important and often overlooked subject. He thought that the action of these waters, containing as they do, only small amounts of the various salts, is explained by the absolute solution in which these salts are held. He mentioned Hunyadi and Vichy waters as two of the most generally useful.

Dr. A. P. Reid introduced to the meeting a circular from the Provincial Board of Health, dealing with Milk Supply, Bovine Tuberculosis, Sewage Disposal, etc. He distributed copies to the members.

Before adjournment the president read a card from the Royal Cape Breton Yacht Club, extending the privileges of the club to the members of the Society during their stay in Sydney.

AFTERNOON SESSION, 2.30 P. M.

Dr. Hattie read the report of the Committee on Education, which will be published in next issue.

Dr. S. J. McLennan, Glace Bay, read a paper, "Some Observations on Middle Ear Disease."

The Vice-President, Dr. H. V. Kent, was then called to the chair and Dr. A. S. Kendall delivered the Presidential address.

On motion, the Presidential address was referred to a committee, consisting of Dr. John Stewart, J. W. McLean and E. D. McLean.

Dr. D. A. Campbell read "Notes on a recent visit to the Kentville Sanatorium."

Dr. R. A. H. MacKeen said that the increase in tuberculosis in and about Glace Bay was remarkable. He agreed with much of Dr. Campbell's paper, but thought that the results of sanatorium treatment were often disappointing. He was strongly in favour of the appointment of a resident Medical Superintendent at the Kentville Sanatorium, and also the reduction of the cost to deserving cases. He regarded tuberculosis treatment, properly carried out, as a necessary adjunct to the sanatorium. He also favoured enlargement of the present building.

Dr. A. P. Reid pointed out that the Kentville Sanatorium was merely designed as a model for the municipalities of the province, and that it was intended solely for incipient cases. The chief point is that each municipality must be responsible for its own sick. He referred to the successful work of Dr. S. N. Miller of Middleton in outdoor treatment at home of tuberculosis cases.

Dr. Mader thought that a most important point was the careful watching of the patient's condition after his return from the sanatorium.

Dr. S. N. Miller considered sunlight as of prime importance. He uses square canvas tents with open sides,

sometimes curtained, for outdoor treatment, which he carries out rigorously regardless of weather. He cited a number of cases in which he had obtained good results.

The meeting adjourned, after which the members and their friends attended a very enjoyable garden party at the beautiful grounds of Mr. MacLellan, to which they were conveyed by steamer.

In the evening, three public meetings, at Sydney, North Sydney and Sydney Mines, were addressed by members of the Society on the subject of tuberculosis, with a view to the formation of an Anti-tuberculosis League in this section of the province.

Annual Meeting Of The Annapolis-Kings Medical Society.

THE Annual Meeting of the Annapolis-Kings Medical Society was held in Middleton, N. S., on June 24th, 1909, with Dr. DeWitt, President of the Society, in the chair, and a good attendance of the officers and members. Dr. Payzant, of Wolfville, Chairman of the Committee on Biographical Information, reported. He hoped to have an opportunity of visiting the different communities soon, and expressed the wish that all members of the Society would aid his work by noting in a blank book any information they could obtain concerning the life and work of the practitioners of the first half of the last century.

Dr. DeWitt then read his report for the year, giving a very exhaustive review of the work of the Society during the first two years of its existence in which he has been president, and pointed out very clearly the duty of the members in regard to public health and preventive medicine.

The report of the secretary-treasurer showed the financial condition to be in a healthy state.

The following officers were then elected by ballot:—

President—Dr. S. N. Miller, Middleton.

Vice-President (Annapolis County)—Dr. M. E. Armstrong, Bridgetown.

Vice-President (Kings County)—Dr. W. B. Moore, Kentville.

Members of Executive Committee—Dr. L. R. Morse, Lawrencetown; Dr. J. B. March, Berwick.

Secretary-Treasurer—Dr. W. F. Read, Middleton.

Dr. Armstrong gave notice that at a future meeting he would move that this Society adopt the code of ethics of the Canadian Medical Society. Dr. Moore invited the Society to hold its next meeting in Kentville, and on motion the invitation was accepted, the date to be arranged by the Executive Committee.

The manager of the Wilmot Spa Springs Co. invited the members of the Society to take a drive to the celebrated Spa Spring, which was accepted, and the pleasant drive was much enjoyed by all.

Public Meeting in Morrison's Hall.

A public meeting of the Society was held in the evening and many of the citizens of Middleton and vicinity availed themselves of the chance to

hear the able and instructive addresses on the great question of tuberculosis, which was held under the auspices of the Middleton Board of Trade. The President of the Board, Mr. C. W. Montgomery, occupied the chair and in a very cordial manner welcomed the Society and commended them for the interest they were taking in matters of public health. The address of the evening was by the retiring president, Dr. G. E. DeWitt. Subject, "Hints of the Progress of Preventive Medicine," which was very carefully listened to by a very appreciative audience.

Dr. A. P. Reid, the Provincial Health Officer, took up the discussion of the paper in a very concise and clear retrospect of the subject as it bore on the public health and tuberculosis and bovine transmission.

Dr. W. B. Moore, of Kentville, continued the discussion, and made a very strong plea for more effective co-operation by the people with the medical profession in the matter of preventive medicine.

At the close of the meeting the members of the Society were very pleasantly entertained at the home of President and Mrs. Miller.

Willard F. Read, Secretary.

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W. W. Keen, Philadelphia (*Journal A. M. A.*, June 26), in an address before the students of the medical de-

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RESPONSIBILITY OF PHYSICIANS IN CASES WHICH MENACE PUBLIC SAFETY.

W. R. Dunton, Towson, Md. (Journal *A. M. A.*, June 26), takes as his text a paper by Dr. P. C. Knapp on "General Paralysis as a Menace to Public Safety," which appeared in the *Boston Medical and Surgical Journal* over a year ago. The paper discussed particularly the nervous and mental conditions of railroad men, especially engineers, and the dangers to the public through their neglect. Dunton states that after reading the paper by Knapp, and other publications on the same subject, he took the matter up with an official of one of the railroads in Maryland. This man recognized the importance of the subject and the matter was referred to the chief surgeon of the road, who,

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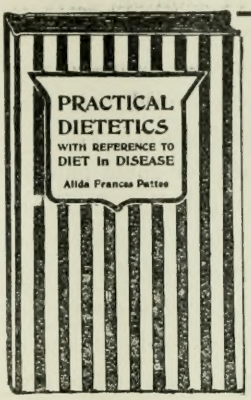

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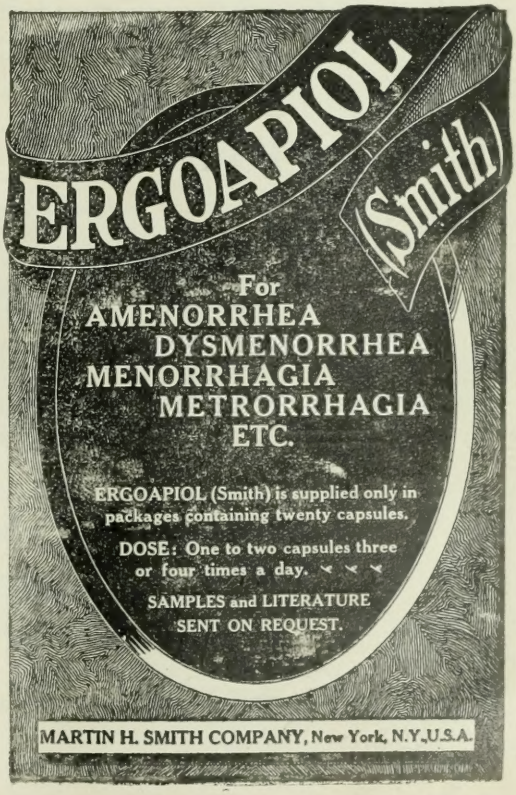

to the amazement of Dunton, gave it as his opinion that neurologic examination of engineers was unnecessary because: (1) the men would not submit to such an examination; (2) rejection of a candidate for some neurologic symptom would bring forth a protest which it would be difficult to answer satisfactorily; (3) following a candidate's rejection the union to which he belonged would make a strong protest. This last objection seemed to be the most important to all railroad surgeons.

Dunton discusses the methods of examination of railroad men now in vogue and expresses himself as dissatisfied with them. He cites cases illustrating the dangers of accident due to defective eyesight of the engineer or incipient paresis. He concludes his paper as follows: "If a physician has as a patient a person unfit to hold a responsible position and a menace to public safety he should endeavor to have the patient voluntarily give up such a position, or if circumstances are such that there is no immediate danger the patient may continue in it under observation. If the last is impracticable and if the patient refuses to be guided by medical advice, some steps should be taken to have the patient removed from this position. We physicians should also endeavor to have transportation companies institute such tests as will insure against the employment of those likely to be a menace to public safety."

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